Financial Eligibility and Assets Certification

Ryan White CARE/HIPP Program

This form must be completed and signed by the client at the time of original application, and at annual recertifications (12 and 24 months). An original signature is required on this form.

Client's name: (last) (first) (MI)	Date of Birth	Social Security Number	Mother's Maiden Name

Street Address	City	State	Zip	Telephone

Type if Insurance	Type of Coverage	Premium amount	Due on
☐ Cobra ☐ Obra ☐ Private policy ☐ Cal-Cobra ☐ HIPPA (RX)	☐ Individual ☐ Family	$ per month	

Financial Eligibility Documentation: Please include information to substantiate information (payroll stub, SSA or SDI award/denial letters, and Medi-Cal notice)

Sources of Family Income	Amount	Date Began	Ending Date (if known)
☐ **Supplemental Security Income**	_____	_____	_____
☐ **Social Security Disability Income**	_____	_____	_____
☐ **State Disability Income**	_____	_____	_____
☐ **Temporary Assistance for Needy Families**	_____	_____	_____
☐ **Unemployment benefits**	_____	_____	_____
☐ **Long Term disability benefits**	_____	_____	_____
☐ **Wages (part time)**	_____	_____	_____
☐ **Other:** _____	_____	_____	_____
TOTAL MONTHLY INCOME	**----------**		

Will income change in next 12 months? ☐ **yes** ☐ **no**

Assets Value Verification: Indicate all property/resources listed below owned, controlled, used, held jointly with another individual, Verification must be provided for all assets.

Property or Resources	Yes	No		Yes	No
Cash (on hand or elsewhere)	☐	☐	Uncashed checks	☐	☐
Checking accounts	☐	☐	Savings accounts	☐	☐
Credit union accounts	☐	☐	Stocks or Bonds	☐	☐
Certificates of Deposit	☐	☐	Money Market Accounts	☐	☐
Trust Funds	☐	☐	Notes, Mortgages, Deeds of Trust	☐	☐
Employee deferred Compensation plans	☐	☐	Other _____	☐	☐

If you answered yes to any of the above resources, please complete the section below:

Resource type	Owner	Value
		$
		$
		$
		$

Total Assets Value $_____

Medi-Cal Application Date (If assets are less than $2,000.00) _____

Declaration: I have thoroughly read and understand the provisions of the CARE/HIPP enrollment policy. I further agree to provide documentation to substantiate my eligibility***. I agree to immediately notify my benefits counselor of any changes in my circumstances which affect program eligibility or health insurance coverage.*** I understand my health insurance premiums will be paid as long as I am eligible, until I enroll in the state HIPP program, or until I am Medicare eligible or 29 months, whichever comes first.

Client Signature	**Date**	**Policy Holder signature (If different)**	**Date**

Benefits Counselor Signature	**Date**